

**PLAINTIFF’S BURDEN OF PROOF – FAILURE LEADS TO DISMISSAL:
A SUMMARY OF RECENT CASES**

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Plaintiff’s Burden of Proof

All actions are commenced by the filing of a complaint in a court of law. Listed in the complaint are allegations set forth by the plaintiffs enumerating facts and allegations of acts or omissions of the defendants, which plaintiffs claim proximately caused the injuries to the plaintiffs. With the complaint comes the responsibility of the burden of proof – proving by a preponderance of the evidence, that it is more likely than not that the acts or omissions were the proximate cause of the plaintiffs’ injuries.

Plaintiffs have the burden of producing evidence and persuading the jury of its existence, and they bear the risk of failure of proof or persuasion. Plaintiffs, in a negligence allegation, whether in a design or manufacturing defect case, have the burden of proving that defendants’ acts or omissions were the proximate cause of the plaintiffs’ injuries. If the plaintiffs fail to prove their case by a preponderance of the evidence, the case will be dismissed against the defendant.

The burden of proof can also be considered a dual one. The plaintiff has the burden to prove the allegations in the complaint and the burden is also on the defendant to counter with evidence the prima facie case established against it.

In the press, within the reaches of the public, more exposure is given to cases in which huge verdicts, usually involving multi-millions of dollars, have been awarded to plaintiffs. Notable ones are *BMW v. Gore*,¹ in which Gore was awarded at a jury trial \$4,000,000.00 in compensatory damages and \$4,000,000.00 in punitive damages against BMW for BMW’s failure to inform Gore that his recently purchased “new” BMW had been repainted (punitive damages were reduced by the Alabama Supreme Court to \$2,000,000.00 and thereafter reversed and remanded by the United States Supreme Court). Another memorable case was *State Farm Mutual Automobile Insurance Co. v Campbell et al.*,² in which a jury awarded the Campbell’s \$2,600,000.00 in compensatory damages and \$145,000,000.00 in punitive damages on their bad faith, fraud, and intentional infliction of emotional distress claims. The trial judge remitted this amount to \$1,000,000.00 for compensatory damages and \$25,000,000.00 in punitive damages. On appeal, the Supreme Court of Utah reinstated the original jury verdict of \$145,000,000.00 in punitive damages. The punitive damages award was reversed and remanded by the United States Supreme Court and judgment for punitive damages was eventually entered for \$9,018,780.75. Lesser publicized cases involve situations where the plaintiffs have not prevailed and where, in the interest of justice, defendants have prevailed and had their cases dismissed.

¹ 517 U.S. 559 (1996)

² 538 U.S. 408 (2003)

This article will discuss three recent cases in which the plaintiffs have failed in their burden of proofs, and in which defendants have succeeded in convincing the jury, or the courts, with evidence against the prima facie case made against that party and the paths taken by each one.

Cases

Judy Greene et al., v. B.F. Goodrich Avionics Systems, Inc. d/b/a B.F. Goodrich Aerospace, Avionics and Lighting Division, n/k/a Goodrich Avionics Systems, Inc., et al., 409 F.3d 784 (6th Cir. 2005)

Judy Greene commenced an action for the death of her husband, Donald Greene, who was piloting a Sikorsky 76-A helicopter, owned by Petroleum Helicopters, Inc. (PHI) which crashed near Jackson, Kentucky, on June 14, 1999. Prior to the accident, due to poor visibility, Greene was relying almost exclusively on the helicopter's navigational instruments. Within a few minutes of the aircraft's take-off, Greene announced to the pilot-in-command that "I think my gyro just quit." Soon thereafter, the aircraft crashed, killing all occupants on board.

There were at least six gyroscopes on the helicopter, of which Goodrich manufactured two. The remaining gyroscopes were manufactured by other entities. The vertical gyroscopes manufactured by Goodrich provided data to the helicopter's Attitude Display Indicators (ADIs). The helicopter was equipped with two such ADIs, which indicate an aircraft's position in relation to the earth's horizon and assists the pilot in controlling the position of the helicopter relative to the earth. Each ADI in the aircraft displayed pitch, roll, and turn-rate data. The ADIs were not manufactured by Goodrich. The vertical gyroscopes were located inside the nose of the helicopter and were not visible to the pilots during the flight. Each ADI received pitch and roll data independent from its own vertical gyroscope. Each ADI also received turn-rate data from two other gyroscopes not manufactured by Goodrich.

Greene claimed Goodrich defectively designed or manufactured the vertical gyroscopes and negligently failed to warn of the defective product. After motion practice, the only allegation at trial Goodrich had to defend against was the manufacturing defect-strict liability claim. Under that theory, the plaintiff had to establish that the product (the gyroscope) was in a defective condition unreasonably dangerous to the user or consumer, and that defendant's conduct was a substantial factor in bringing about plaintiff's harm. Under Kentucky law, circumstantial evidence could be used to prove the plaintiff's case so long as the evidence was sufficient to shift the balance from possibility to probability that the allegations were true.

After all the evidence was presented, a jury found for Greene and awarded her substantial damages. Goodrich appealed claiming the trial court erred, among other reasons, by not granting Goodrich's motion for judgment as a matter of law at the close of the plaintiff's case. Goodrich argued that the plaintiff failed to meet her burden of proof

because she failed to establish an issue of fact for the jury that there was a manufacturing defect in the pilot's vertical gyroscope, and that the evidence failed to shift the balance from possibility to probability that there was a manufacturing defect in the pilot's vertical gyroscope. The appellate court agreed, setting aside the jury verdict, reversing the district/trial court's denial of Goodrich's motion for judgment as a matter of law at the conclusion of the plaintiffs' case, and remanding the case with instructions to enter judgment in favor of Goodrich and dismiss the case.

In presenting her case to the jury and on appeal, the plaintiffs relied on circumstantial evidence to prove their claim since the vertical gyroscopes were destroyed in the crash, so there was no direct evidence of vertical gyroscope failure. The circumstantial evidence consisted of:

1. Donald Greene's statement seconds before the crash that he thought the "gyro just quit."
2. Evidence that 6 months before the crash there were "numerous" gyroscope replacements on similar Sikorsky helicopters owned and operated by PHI (Notably, there were also 11 ADI replacements on 7 PHI helicopters).
3. The NTSB retrieval from the crash site of a faceplate of one of the helicopter ADIs, which purportedly revealed that the CVR tape and the crash kinematics did not match the reading of the recovered ADI.
4. Plaintiff's expert testimony in which he opined that a vertical gyroscope failure, rather than a failure of other instruments, was the cause of the crash; that a wiring failure between the vertical gyroscope and its ADI was not as typical as a gyroscope failure itself; and, that the accident was a result of "instrument confusion in the cockpit created by the loss of vertical gyro input to the flying pilot's ADI or gyro horizon."

Goodrich argued that since there were at least six gyroscopes on the helicopter, and it did not manufacture all of them, Greene's statement that the gyro quit was speculation as to which gyroscope he was referring to. Goodrich also argued that there were equally other plausible causes of the accident, including faulty wiring between the ADI and the gyroscopes, other faulty gyroscopes, faulty ADIs, and/or pilot error (Incidentally, the NTSB concluded that pilot error was the cause of the accident. This was, of course, inadmissible at trial).

The appellate court held that the removal/repair of the gyroscopes did not suggest there was a manufacturing defect, as Greene proffered no evidence that the reasons for the removal or repairs of the vertical gyroscopes were unusual, or that the rate of replacement of vertical gyroscopes in the PHI fleet differed from the replacement rate of vertical gyroscopes made by other manufacturers. Including ADIs within the list of removal, replacements and repairs did not support Greene's claim that there was a manufacturing defect in the gyroscope, but the evidence equally suggested that there

could have been a problem with the ADI, which was not manufactured by Goodrich. There was no evidence to rule out the possibility that the ADI malfunctioned. The appellate court also held that the failure to produce evidence of the gyroscope's expected useful life in order that they may compare that to whether the removal, replacement and repairs were done at a significant rate was attributed to the plaintiff – the party with the burden to prove a manufacturing defect.

The court also held that work performed on two vertical gyroscopes that were removed from the accident aircraft six months prior to the crash were not probative of a manufacturing defect, as both work orders indicated that the vertical gyroscopes were either repaired or tested and met manufacturer specifications when they were returned to PHI. The work performed did nothing to suggest that the gyroscopes were defective at the time the gyroscopes left Goodrich's manufacturing plant.

Furthermore, as previously stated, the plaintiff's expert testified and opined that 'the accident was a result of instrument confusion in the cockpit created by the loss of vertical gyro input to the flying pilot's ADI, or gyro horizon.' In rebuttal to this, the PHI lead pilot testified that even if one ADI failed or was receiving incorrect information, the pilots should have relied upon other ADIs in the cockpit to safely fly or land the aircraft.

The plaintiff's expert also testified that the accident was caused by a number of factors which included two primary causes: the weather, and, the helicopter experiencing instrument failure.

The appellate court held that the plaintiff failed to provide sufficient evidence that there was a manufacturing defect, and failed to produce sufficient evidence to shift the balance from possibility to probability that defendant's conduct was a substantial factor in bringing about plaintiff's harm. Plaintiff's evidence was insufficient to prove there was a manufacturing defect since it was also possible the ADI was defective; removal and replacement of gyroscopes were not shown to be unusual; that the pilot should have been able to navigate the helicopter if the ADI failed; and, that multiple events could have caused the helicopter crash.

Stewart, et al. and Fraley et al., v. Learjet, Inc., No. CIO-00-7811 (Ninth Judicial Circuit, Orlando, Florida June 8, 2005)

The families of Payne Stewart (a professional golfer) and Robert Fraley (a sports agent) sued Learjet, Inc. for wrongful death out of the crash of a Learjet 35. Mr. Stewart's estate was claiming past and future economic losses and non-economic losses totaling \$150,000,000.00 and Mr. Fraley's Estate was claiming similar losses totaling \$50,000,000.00. Learjet, Inc. was the manufacturer of the aircraft.

NTSB Report³

³ National Transportation Safety Board Aircraft Accident Brief, accident No. DCA00MA005

On October 25, 1999, at approximately 12:13 P.M. Central Daylight Time (CDT), a Learjet Model 35, N47BA, operated by Sunjet Aviation, Inc. of Sanford, Florida, crashed near Aberdeen, South Dakota. The aircraft departed Orlando, Florida for Dallas, Texas, about 9:20 A.M. eastern daylight time (EDT). Radio contact to ATC from the aircraft was made at 9:27:18 A.M. EDT and the next contact attempted by ATC to the aircraft was at 9:33:38 A.M. EDT. After receiving no response for the next 4½ minutes, several U.S. Air Force (USAF) and Air National Guard (ANG) aircraft were sent to intercept the aircraft as it proceeded Northwest bound, at the request of Jacksonville authorities. The military pilots who observed the aircraft stated that the forward windshields of the Learjet seemed to be frosted or covered with condensation. The military pilots could not see into the cabin. They eventually observed the aircraft depart controlled flight and spiral to the ground impacting an open field. All occupants on board the aircraft were killed, and the aircraft destroyed.

The flight crew's failure to respond to repeated ATC radio inquiries beginning at 9:33:38, when the aircraft was climbing to about 36,400 feet, was the first indication of a problem on board the accident flight. As the flight continued, it deviated from its assigned course and failed to level at its assigned altitude (FL 390). Over the next 4 hours there was no evidence that the flight crew attempted to intervene as the aircraft continued to fly off course, ascending to 48,900 feet, and finally descended to impact. The aircraft's maximum operating altitude is 45,000 feet. Information from the CVR indicated that the aircraft's final descent was initiated by the engine ceasing to operate, most likely caused by fuel exhaustion. The NTSB determined that these events indicated that the flight crew members became incapacitated at some point during the 6 minutes and 20 seconds between 09:27:18 and 09:33:38.

The continuous sounding of the cabin altitude aural warning (a unique aural warning in the Learjet Model 35/36) during the final 30 minutes of cruise flight indicates that the airplane and its occupants experienced a loss of cabin pressurization some time earlier in flight and that there was no evidence suggesting any alternative reason for incapacitation.

Pressurized cabins of turbine-powered aircraft typically maintain pressurized aircraft cabins of a consistent environment equivalent to that of 8,000 feet by directing engine bleed air into the cabin while simultaneously regulating the flow of air out of the cabin.

The NTSB determined that the left and right bleed air shutoff/regulator valves (modulation valves) indicated that they were near their fully closed positions, which is consistent with a normal and adequate supply of engine bleed air from one or both engines. The nearly closed positions indicate that there was a low demand for bleed air by the airplane's air conditioning and anti-icing systems.

The flow control valve regulates the flow rate of conditioned bleed air entering into the cabin for pressurization and heating. If there is no inlet bleed air, the flow

control valve will close completely. Although bleed air was available to open the flow control valve, the condition of the flow control valve indicated that it was in its fully closed position before and at impact. This closed valve would have prevented bleed air from entering the cabin, thereby preventing normal pressurization.

Closure of the flow control valve on the aircraft and the resulting loss of bleed air supply to the cabin would cause the aircraft to quickly lose cabin pressure at a rate dependent on cabin leakage rate. Computer simulations indicated that if a loss of normal bleed air supply to the cabin occurred at flight altitudes above 25,000 feet (which the aircraft had attained), the cabin altitude could ascend to 10,000 feet in about 30 seconds and reach 25,000 feet in about 2½ minutes. At cabin altitudes above 10,000 feet, the reduction in the partial pressure of oxygen impedes its ability to transfer across lung tissues into the bloodstream to support the effective functioning of major organs, including the brain. At a cabin altitude of 20,000 feet, flight crewmembers would have likely been impaired by hypoxia, a condition resulting from lack of oxygen leading to impaired vision, judgment or motor control, drowsiness, slurred speech, memory decrements, difficulty thinking, and loss of consciousness and death.

The NTSB determined that the first officer, who performed all the communication with ATC was not using an oxygen mask microphone (and therefore did not have an oxygen mask on) during any of the transmissions with ATC since her speech was normal, her phraseology accurate and appropriate and by comparing transmissions with normal microphones and with an oxygen mask microphone made during a test flight. The NTSB could not explain why the pilots did not or could not receive supplemental oxygen in sufficient time and/or adequate concentration to avoid hypoxia and incapacitation.

The military pilots reported that the accident aircraft's windshield was obscured by condensation or frost which is consistent with a loss of bleed air supply to the cabin. When bleed air supply is supplied to the cabin, the cockpit windshield receives a constant flow of warm air that prevents or removes condensation, regardless of ambient air or loss of pressure to the cabin. Thus, the windshield would be relatively clear following depressurization from a breach or other undesired outflow from the cabin with continued bleed air supply to the cabin, whereas condensation could form and remain on the windshield following a depressurization caused by a loss of bleed air inflow to the cabin. Therefore, the NTSB determined that the accident aircraft most likely did not have an inflow of bleed air to the cabin.

The NTSB determined that there was no evidence of an earlier pressurization problem (such as an outflow valve malfunction or a break in the fuselage) preceding the closing of the flow control valve. However, NTSB investigators considered the possibility that the flight crew might have experienced or were reacting to what they perceived to be such a problem and that the closed position of the flow control valve could have been a consequence of the flight crew's attempt to address a pressurization malfunction or failure (cause unknown), rather than its cause. An uncommanded closure of the flow control valve would have been sufficient to depressurize the plane but there was insufficient evidence to determine whether the pressurization was initiated by a loss

of bleed air inflow (caused by a malfunction of the flow control valve or by inappropriate or incomplete flight crew action) or by some other event. The Board could not exclude the possibility that the flow control valve closed uncommanded because of a mechanical malfunction.

The NTSB also determined that maintenance actions by Sunjet from July 22, 1999, through October 23, 1999, indicate that there were several pressurization-related discrepancies during this period and maintenance records indicate Sunjet personnel attempts to correct the discrepancies. Work performed on October 23, 1999, related to concerns about the pressurization system; however, Sunjet was unable to provide records of pilot-reported discrepancies that led to these maintenance actions as required by its General Operations Manual. If these records were provided, the NTSB may have learned additional details about the frequency and nature of the aircraft's prior pressurization-related problems and may have been able to determine whether they were related to a common problem. Additionally, the investigation revealed that maintenance work performed on the pressurization system had not been signed off by mechanics or inspectors, and that Sunjet then operated the aircraft on revenue trips with deferred maintenance on the pressurization system.

Ultimately, the NTSB determined that the probable cause of the crash was incapacitation of the flight crewmembers as a result of their failure to receive supplemental oxygen following a loss of cabin pressurization, for undetermined reasons.

Trial⁴

At trial, the plaintiffs attempted to show that the accident was caused by crew incapacitation resulting from cabin depressurization at high altitude, caused by a failure of a valve adapter that resulted in an outflow valve pulling away from the fuselage causing a 3 inch hole in the nose. The resulting hole caused cabin pressure to plummet, rendering the flight crew unconscious. The plaintiffs argued poor design, lack of testing, and weak materials caused the adapter to fail. After crew incapacitation, this led to an unmonitored flight, unmanaged fuel consumption, eventual fuel exhaustion, engine flameout and an uncontrolled collision with the ground.

Learjet maintained that damage to the adapter was caused by the impact from the crash. The adapter was a part which was approved by the FAA, and did not fail causing the crash as this had never occurred in any Model 35 Learjet, even though more than 300 of them were in service worldwide. The part had no history of failures. However, even if it did fail, it could not fall away because of the pressurization in the aircraft. Rather, Learjet argued that maintenance problems, poor pilot training (in failing to react quickly to depressurization) and management issues at Sunjet led to the events that resulted in the accident.

In the month-long trial the plaintiff did not set forth sufficient evidence to show by a preponderance of the evidence that the aircraft crashed as a result of a design or

⁴ Source received from court documents, and various legal and news articles and journals

manufacturing defect, and after a 6-hour deliberation, the jury determined that the plaintiff Learjet was not liable for the October 1999 plane crash that killed Stewart.

Julio Cesar Wilson Stajano and Ana Maria Delgatte de Stajano, as Parents and Natural Guardians of Infant Plaintiff Chantal Delgatte Stajano, and Julio Cesar Wilson Stajano and Ana Maria Delgatte de Stajano, Individually v. United Technology Corporation of New York City and United Technologies Corporation and Sikorsky Aircraft, Inc., Supreme Court of the State of New York, County of New York, Index No. 3052/80⁵

Plaintiffs, all residents of Uruguay, brought actions against defendants to recover damages for personal injuries arising out of a 1971 accident in Montevideo, Uruguay. According to the plaintiffs, the Uruguayan military was performing an air show on a bluff and a beach in Pocitos, Montevideo, Uruguay. Two Uruguayan military helicopters, which had been purchased from the U.S. government in 1971, were parked on a bluff and one was used to demonstrate that it could transport a jeep across the water. To demonstrate this, the pilot's assistants on land ("land assistants") placed strong belts to the vehicles forming a mooring. The operation did not run smoothly and the pilot had to make several attempts to haul the vehicle up. After some time, the land assistants managed to secure the belts around the jeep in such a way that the helicopter could lift into the air with the jeep hanging underneath it, utilizing the cargo belly hook underneath the helicopter. The helicopter, with its dangling jeep, flew out over the ocean. One of the belts hooked to the jeep became unfastened and the released corner of the jeep sagged sharply downward. This caused the helicopter's center of gravity to shift and the aircraft began to lose altitude. The pilot headed back to shore, presumably, to land the helicopter near where it had departed from. However, as the helicopter lost altitude, it approached the bluff where the second helicopter was idling, and the jeep slammed into the side of the cliff. The impact caused the airborne helicopter to crash onto the idling helicopter causing fuel tanks of both helicopters to explode. In the ensuing inferno, metal projectiles including shards of rotor blades and bullets from the machine guns that were inside of the helicopters erupted in all directions, killing 8 people instantly and injuring scores of others, including the plaintiffs. The crew of both aircraft were able to escape with their lives.

The plaintiffs' experts claimed that the accident was caused as a result of manufacturing defects and design defects, and brought suit against defendants. The plaintiffs claimed that proper procedure to be performed when the load becomes unsecured, as the jeep did here, is for the pilot to release the load rather than endanger the aircraft. There was a cargo release switch on the pilot's and co-pilot's cyclical stick and a cargo release pedal on the cockpit floor next to the pilot's right foot. The plaintiffs' experts opined that the electrical cargo release switch on the pilot's and co-pilot's cyclical control sticks "must have" malfunctioned; that the back-up mechanical cargo release pedal on the cockpit floor next to the pilot's right foot "must have" failed as well;

⁵ Decision, Order and Judgment dated October 8, 2002

and, that the aircraft was defectively designed because there was no redundant foot pedal close to the co-pilot so that the jeep could have been jettisoned.

The lower court granted summary judgment to the defendants primarily based on the government contractor defense and dismissed the complaint.⁶ Additionally, the court wrote in its decision, in a parenthetical footnote, that even without the government contractor defense, the plaintiffs had no case. The court held that the plaintiff failed to set forth any evidence that when the jeep became unsecured that the pilot or co-pilot ever attempted to release the jeep and the release systems failed. The court cited a number of possibilities for how the accident happened, including poor pilot training as they may not have known of the existence of the releases or they may have panicked and failed to follow proper procedures by attempting to release the load. The jeep could have been overweight or incorrectly secured to the cargo hook, such that no amount of pushing on the releases would have released the load. Even if the cargo release had failed, it could have been attributed to improper maintenance by the Uruguayan government who were not defendants in the action. Even if the releases failed, the plaintiffs failed to show how a co-pilot's foot pedal would have prevented the accident.

The lower court attributed the lack of evidence, on these issues, solely on the plaintiffs for having failed to obtain statements from the pilot and co-pilot; failed to provide a precise description of the arrangement of switches and dials in the cockpit; failed to interview the land assistants who fastened the jeep to the helicopter; failed to provide evidence of the pilot and co-pilot's training; and, failed to show evidence of the weight of the jeep and maintenance of the aircraft.

The order was affirmed by the State of New York, Appellate Division, First Department. A motion for leave to appeal to the Court of Appeals of the State of New York was denied. Petition for certiorari was denied by the Supreme Court of the United States on May 31, 2005, and an order of dismissal was ordered to be entered by the Supreme Court of the State of New York.

Conclusion

As demonstrated above, by the jury and the courts, the plaintiffs have the burden of producing evidence and persuading the jury of its existence. When they fail in this exercise they bear the risk of failure of proof or persuasion.

The burden is a difficult one to accomplish and even so for the defendant who bears the burden to counter with evidence the prima facie case established against it. It has stood the test of time, but the theory holds that in every litigation, in every lawsuit commenced, and in every case taken to trial, the burden has to be met before either the plaintiff can recover or the defendant can and will be dismissed.

⁶ Decision, Order and Judgment dated October 8, 2002